

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 013164	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
NAME OF PROVIDER OR SUPPLIER SOLANA SENIOR LIVING, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 7721 BATTERY POINTE WAY INDIANAPOLIS, IN 46240		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00171067.</p> <p>Complaint IN00171067 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey Date: April 15, 2015</p> <p>Facility number: 013164 Provider number: NA AIM number: NA</p> <p>Census bed type: Residential: 74 Total: 74</p> <p>Census payor type: Other: 74 Total: 74</p> <p>Sample: 3</p> <p>Solana Senior Living LLC was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00171067.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE